

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005052	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/10/2013
NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST FRANCIS HEALTH - MOORESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 HADLEY RD MOORESVILLE, IN 46158		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for a State complaint.</p> <p>Complaint #IN00126040 Substantiated; no deficiencies related to allegations are cited.</p> <p>Date of Survey: 10-10-13</p> <p>Facility number: 005052</p> <p>Surveyor: John Lee, R.N. Public Health Nurse Surveyor</p> <p>Franciscan St Francis Health - Mooresville is in compliance with 410 IAC 15-1.5-5, Medical staff, and 410 IAC 15-1.5-7, Pharmaceutical services, Hospital Licensure Rules.</p> <p>QA: cloughlin 10/18/13</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE